Name: ____Birthdate:_____________Date:_____________

PATIENT PREFERENCES:

Primary Care Physician: ____

Local Pharmacy and Phone Number: ____

Mail Order Pharmacy: ____

Imaging Center: Gwinnett Medical Center Eastside Emory John's Creek Breast Care Specialists

Northeast Georgia _____________ Northside ______________ Other________________

MEDICATIONS: Please list any medications that you take: prescription, over the counter, and vitamins.
IF YOU HAVE A LIST OF MEDICATIONS WITH YOU PLEASE ASK THE FRONT DESK TO MAKE A COPY AND SKIP THIS SECTION.

Name	Dosage	How often

GYNECOLOGY QUESTIONS

1. **Are you sexually active? Yes/No If yes, have you had any new sexual partners? Yes/No**
2. **Do you desire testing for sexually transmitted disease? Yes/No**
3. **Sexual orientation: (please circle one) Heterosexual Bisexual Homosexual Transgender**
4. **What do you use for contraception (to prevent pregnancy)? ____________________________**

MENSTRUATING WOMEN ONLY:

First day of last period____________ Length of flow: _____________ Monthly cycles: YES or NO

Amount of bleeding: (please circle one) SCANT / LIGHT / MODERATE / HEAVY

MENOPAUSAL WOMEN ONLY:

Age at menopause: ____________

Hormone replacement therapy: (please circle all that apply)

NEVER / CURRENT / PAST USE/WOULD LIKE TO DISCUSS/WOULD LIKE TO CONTINUE

Have you had any bleeding in the last year? ________________

SOCIAL HISTORY: Please answer ALL questions. Circle the one that applies to you or fill in the blank.

Smoking

1. Never/Current/ Past Use
2. How many cigarettes daily? _____
3. Would like to quit? Yes/No

Alcohol Use:

1. Never/Occasional/ Moderate/Heavy
2. History of alcohol abuse? Yes/ No
3. How many days in the last year have you had more than 4 drinks in one day? ____

Drug Use:

1. Never / Current Use / Past Use
2. Rehab: Current / Past / Never

Occupation: ____________

Religion: ______________

Marital Status

Single/ Domestic Partner/ Married/Separated/Divorced/ Widow

Domestic Violence:

1. Do you feel safe at home? Yes/No
2. Do you have a history of emotional/physical/sexual abuse? Yes/No

Hobbies/Activities: _____________________

Stress Level:

1. Low/Medium/High

Have you recently traveled to or lived in a Zika affected area? Yes/No

Do you have any symptoms associated with the Zika Virus? Yes/No

REVIEW OF SYSTEMS: Please circle any problems that you are currently experiencing

CONSTITUTIONAL: fatigue, weight gain, weight loss
LUNGS: cough, wheezing, shortness of breath
CARDIOVASCULAR: chest pain, palpitations, swelling of extremities
BREAST: mass, tenderness, skin changes, nipple discharge
GASTROINTESTINAL: abdominal pain, nausea, vomiting, constipation, bloating, diarrhea, change in bowel movements, rectal bleeding
GENITOURINARY: urinary urgency, urinary frequency (urinating more than 8 times a day), pain with urination, pelvic pain, blood in urine, getting up at night to urinate, leaking urine, vaginal discharge, vaginal odor, vaginal itching, vaginal burning, vaginal irritation, lesions, bleeding (if you are menopausal)
ENDOCRINE: change in appetite, cold intolerance, heat intolerance
MENSTRUAL: irregular periods, PMS symptoms, heavy periods, painful periods
MENOPAUSAL: hot flashes, night sweats, vaginal dryness
SEXUAL: bleeding after intercourse, decreased sex drive, painful intercourse
NEUROLOGICAL: headache, dizziness, memory loss, problems concentrating
HEMATOLOGIC: swollen glands
SKIN: rash, abnormal moles, hair loss
PSYCHIATRIC: depression, anxiety, sleeps disturbances